Department of Health and Human Services

Health Care Financing Administration

Press Office
Washington, DC 20201

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CONTACT: HCFA Press Office
(202) 690-6145

PROTECTING MEDICARE BENEFICIARIES AFTER MEDICARE+CHOICE ORGANIZATIONS WITHDRAW

Background: Medicare managed health care options have been available to some Medicare beneficiaries since 1982. Although some 70 percent of seniors and disabled people covered by Medicare live in areas currently served by at least one managed care plan, only about 6.2 million, or 16 percent of all Medicare beneficiaries, have chosen to enroll in a Medicare health maintenance organization (HMO). Since 1998, most HMO contracts with the federal Health Care Financing Administration (HFCA) have operated under the Medicare+Choice program to provide health care coverage for beneficiaries in certain areas. The Medicare+Choice program was created by Congress in the Balanced Budget Act of 1997.

Medicare+Choice organizations were required to notify HCFA by July 3, 2000, if they would renew their existing contracts for 2001.

Consistent with recent reports, in 2001, about 85 percent of current Medicare+Choice beneficiaries will be able to continue with their current Medicare HMO. Sixty-five Medicare+Choice HMOs chose not to renew their Medicare+Choice contracts and 53 reduced their service areas, affecting more than 934,000 Medicare beneficiaries. About 775,000 of the affected beneficiaries will be able to enroll in another Medicare HMO, if the HMO is accepting enrollees. About 17 percent or 159,000 of the remaining beneficiaries will be left with no Medicare+Choice HMO options, although some may choose to enroll in a private fee-for-service plan if one is available in their community. All beneficiaries who are affected by these non-renewals may return to original fee-for-service Medicare.

HCFA is continuing to do all that it can to ease the transition for affected beneficiaries resulting from business decisions by private sector managed care companies and ensure that they receive the rights and protections guaranteed by law.

HCFA Works With Beneficiaries When Medicare+Choice Organizations Withdraw

Through the approximately $141 million National Medicare Education Program, Medicare & You, HCFA has been working with public and private partners that represent tens of millions of older and disabled Americans to provide information to beneficiaries about their rights and options under Medicare+Choice. As part of this effort, we help beneficiaries understand their options when a plan withdraws. A key piece of this information is that beneficiaries are automatically eligible to return to original fee-for-service Medicare and that they have guaranteed access to some Medigap policies that help fill coverage gaps if their Medicare+Choice organizations leave the program.

Beneficiaries in every community can get the most up-to-date information from HCFA on available coverage options. This fall, HCFA will update information about health plan options for 2001 at 1-800-MEDICARE (1-800-633-4227), HCFA's Medicare Choices Helpline. HCFA will also post new information about plan withdrawals on Medicare's consumer Internet site, www.medicare.gov.

Key partners include the Leadership Council of Aging Organizations, the American Association of Health Plans, AARP, the National Council of Senior Citizens, the National Rural Health Association, the National Committee to Preserve Social Security and Medicare, the National Council on Aging, the Medicare Rights Center, the National Hispanic Council on Aging, the National Caucus and Center on Black Aged and the Older Women's League, as well as the Social Security Administration, HCFA regional offices, the U.S. Administration on Aging and State Health Insurance Assistance Programs.

Medicare+Choice Plan Participation in 2001

About 85 percent of current M+C enrollees will be able to continue with their current Medicare HMO in 2001.

Of the 934,000 beneficiaries affected by plan non-renewals, the majority (775,000) will continue to have a Medicare+Choice plan in their area.

Since July 1998, HCFA has approved 58 applications for M+C organizations to begin service or expand a service area. HCFA recently approved its first private fee-for-service option, which serves 11 total states and portions of six others (a total of over 1,200 counties with 8.2 million Medicare eligibles). HCFA is currently reviewing five new M+C applications, including two preferred provider-type organizations. Five current M+C organizations have submitted service area expansions.

Payments in Affected Areas

Using 2000 enrollment (to account for generally larger enrollment in higher payment areas), the monthly enrollment-weighted average payment per member in 2001 is estimated to be about $573. The weighted average payment rate in 2001 for counties affected by non-renewals is estimated to be about $541, or about 95 percent of the national weighted average payment rate.

Although enrollees in lower payment-rate areas are more likely to be affected by non-renewals, beneficiaries in higher payment areas are also affected. About one-third of enrollees in counties with the floor payment rate of $415 in 2001 are affected by non-renewals. About 18 percent of enrollees living in counties with a payment rate less than the national enrollment weighted average are affected by withdrawals compared to about 11 percent of beneficiaries in counties with a higher than average payment rate.

Medicare+Choice Organizations Make Annual Business Decisions

Since the beginning of the Medicare+Choice program, managed care costs generally have increased at a rate faster than for fee-for-service Medicare, due in part to the fact that some plans provide additional benefits that beneficiaries in original fee-for-service Medicare do not have access to, such as outpatient prescription drugs. Fee-for-service costs are lower because of Balanced Budget Act provisions and the cost containment and waste, fraud and abuse efforts undertaken by HCFA. Because many Medicare+Choice organizations believe that they cannot be competitive by charging a premium or reducing benefits, some have simply decided to withdraw from the program. In fact, decisions by two managed-care companies account for about half of the total number of beneficiaries affected by withdrawals nationwide.

By law, HCFA does not have the flexibility to modify the payment formula, which actually provides payment increases to HMOs, even when fee-for-service rates decline. According to recent testimony by the General Accounting Office (GAO), several factors influence plans' decisions to participate in Medicare+Choice. The GAO has said that, in past years, the withdrawals have represented some plans that entered a market recently, had few enrollees, faced competition with larger market share, or were unable to establish or maintain provider networks. It seems that at least some of these factors continue to be at work; in fact, a new report has shown that half of the largest U.S. hospitals have canceled an HMO contract in the past year.

HCFA continues to work with managed care industry to streamline the requirements for the health plans that are participating in Medicare+Choice while making sure that beneficiaries who choose managed care receive the benefits, protections, and information they need and deserve. HCFA has modified many contract requirements and operations to be more consistent with the other private and other public purchasers. HCFA is also beginning to implement a number of important initiatives that will further streamline administrative procedures and lead to more efficient and consistent oversight.

Beneficiaries May Still Have Options in Areas Where Medicare+Choice Organizations Have Not Renewed

HCFA wants to make sure that beneficiaries know their options and continue to have access to health care. Plans that are not renewing their contracts for the 2001 contract year will continue to provide services to their Medicare enrollees through December 31, 2000. These plans are required to send all affected beneficiaries an information package by October 2, 2000 that explains beneficiaries' options to return to original fee-for-service Medicare or enroll in another Medicare+Choice organization, if one is available. All beneficiaries have the option of returning to original fee-for-service Medicare and may also have rights to supplemental coverage. Beneficiaries also have the option of enrolling in another Medicare+Choice organization, if one is available.

HCFA reviews and approves all materials sent by plans to beneficiaries. HCFA also will remind plans of their responsibility to notify beneficiaries and provide plans with a model letter to do so. Most current enrollees can remain in their Medicare HMO through December 31, 2000, or they can disenroll before that time and either return to original fee-for-service Medicare or enroll in another Medicare+Choice organization, if one is available. If they take no action, they will automatically return to original fee-for-service Medicare on January 1, 2001. Beneficiaries may call 1-800-MEDICARE (1-800-633-4227) for assistance in making the right health care option decision.

HCFA Encourages Plans to Enter Markets Left Without a Medicare+Choice Option

HCFA will expedite review and approval of Medicare+Choice organizations seeking to enter markets that have been left without a Medicare+Choice option or any alternatives to original fee-for-service Medicare. HCFA will give these applications first priority for review, and will help plans enter these areas quickly — as long as they meet quality and other standards that protect beneficiaries. In addition, the Balanced Budget Refinement Act of 1999 provides for bonus pay-

ments in some counties. HCFA has begun the process necessary to pay these bonus payments to plans that meet the criteria outlined in the law.

Beneficiaries May Be Able to Choose Another Medicare+Choice Option

Other Medicare managed care plans and private fee-for-service plans that operate in the same area as a non-renewing plan are required to be open to accept new enrollments during a Special Election Period, October 1 through December 31, unless the plan has a capacity limit. Beneficiaries can choose an effective date of November 1, December 1 or January 1, as long as the plan receives the completed election form before the effective date.

Beneficiaries who enroll in another Medicare managed care plan, if one is available, or a private fee-for-service plan do not need to submit a disenrollment form.

Some beneficiaries living in certain states across the country may choose to enroll in a private fee-for-service plan. These plans may help beneficiaries with their deductibles and other out-of-pocket costs while providing for some extended benefits.

Returning to Original Fee-For-Service Medicare

Beneficiaries who wish to return to original fee-for-service Medicare should make sure that they consider their need for supplemental insurance coverage before they disenroll. The best decision for each beneficiary will vary based on their individual needs. However, if beneficiaries choose to disenroll and return to original fee-for-service Medicare before January 1, 2001, they can complete a disenrollment form available from their plan, a Social Security Administration (SSA) office, Railroad Retirement Board (RRB) office if they are railroad retirees, or the Medicare Choices Helpline – 1-800-MEDICARE (1-800-633-4227). The effective dates of a beneficiary's disenrollment may vary, so beneficiaries should call their Medicare+Choice plan. Beneficiaries who do not file a disenrollment form will automatically be enrolled in the original fee-for-service Medicare plan effective January 1, 2001.

Supplemental Insurance Through Medigap

Congress enacted legislation in 1999 that added a new time period where beneficiaries have access to Medigap policies when a plan leaves Medicare.

Beneficiaries will continue to have certain rights and protections when purchasing Medigap policies. Beneficiaries have two options:

First, beneficiaries in Medicare+Choice plans who want to switch to original fee-for-service Medicare may do so as soon as they receive their final notice from their Medicare+Choice plans. If they choose this option, beneficiaries have 63 days from the date of the notice (from October 2, 2000 until December 4, 2000) to apply for a Medigap policy and be guaranteed the same protections they would have if they waited until their coverage expired on December 31, 2000. To exercise this option, beneficiaries must disenroll from their Medicare+Choice plan in October or November, and arrange for their Medigap policy to start the first day of the next month so they will have seamless coverage between the plans they choose.

Second, beneficiaries may remain enrolled in their plan through the end of the year. As long as they apply for a Medigap policy no later than 63 days after the coverage with the non-renewing HMO expires (December 31, 2000), the beneficiary is guaranteed the right to buy any Medigap policy designated “A,” “B,” “C” or “F” that is available in the state. If the beneficiary applies for one of these Medigap policies no later than March 4, 2001, companies selling these policies cannot place conditions on the policy (such as an exclusion of benefits based on a pre-existing condition) or discriminate in the price of the policy because of health status, claims experience, receipt of health care or medical condition.

CAUTION: Individuals must keep a copy of their HMO’s termination letter to show a Medigap insurer as proof of loss of coverage under this HMO, whether they terminate their membership in October or November or wait until their coverage ends at the end of December. They should also keep a copy of their Medigap application to validate that they acted within 63 days of the final notice of termination.

If beneficiaries dropped a Medigap policy to join their current Medicare managed care plan and they have never enrolled in a similar health plan since starting Medicare, they are guaranteed the right to return to the Medigap policy they dropped if: the Medigap policy they dropped is still being sold by the same insurance company; they disenroll from their current health plan no later than 12 months after they initially enrolled in it (they have to disenroll from their plan before their coverage terminates on December 31, 2000); and they reapply for the policy they dropped no later than 63 days after they disenroll from their Medicare managed care plan.

In addition, beneficiaries who were new to Medicare at age 65 and chose to enroll in their Medicare+Choice plan during their initial election period, and are still in their first 12 months in the Medicare+Choice plan, may choose any

Medigap policy sold in the State, including those providing some outpatient prescription drug coverage. These individuals must voluntarily disenroll from the Medicare+Choice plan before the 12 months ends and apply for the Medigap policy within 63 days of their coverage ending.

Supplemental Coverage for Retirees Enrolled in an Employer-Sponsored Plan

Beneficiaries whose former employer has an arrangement with the Medicare+Choice organization offering the Medicare+Choice plan in which they are enrolled should consult with their employer.

Affected Beneficiaries May Be Able to Retain Their Doctors

Beneficiaries who choose to return to original fee-for-service Medicare will probably be able to continue to see the same physicians that they had seen through the HMO because most HMO physicians — more than 90 percent — also participate in original fee-for-service Medicare. If there are other Medicare+Choice organizations in the beneficiaries' geographic area, some of their current physicians may also participate with those Medicare+Choice plans.

Information on Other Medicare+Choice Plans

Up-to-date information about Medicare+Choice plans currently available in a county is available at 1-800-MEDICARE (1-800-633-4227) and on the Medicare Compare page on www.medicare.gov. Year 2001 information will be available beginning September 15, 2000. This information can be accessed by zip code, by county and by state. (Some Medicare+Choice plans are available only in certain counties within a state or zip code.) Many libraries and senior centers can help beneficiaries obtain information from this source.

General Assistance for Medicare Beneficiaries on Health Insurance Matters

Beneficiaries can contact their State Health Insurance Assistance Program for assistance. They can also contact the U.S. Administration on Aging's toll-free Elder Care Locator at 1-800-677-1116 to be referred to their local area agency on aging.

Medicare+Choice Enrollees Affected by Non-Renewals and Service Area Reductions for 2001